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	175448	A. BUILDING _____ B. WING _____	08/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 WEST 119TH STREET OLATHE, KS 66061

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	Continued From page 1 under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and	F 156		

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provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 55 residents. The sample included 15 residents. Based on record review and interview, the facility failed to provide adequate reason for discharge from skilled services on the Medicare Liability Waivers prior to the resident being discharged for 2 of 3 residents sampled for Liability Notices. (#83 and #26)

Findings included:

- Review of the Notice of Medicare Provider Non-Coverage (CMS-10123) revealed the facility notified resident #83 on 3-15-12 that his/her skilled nursing services would end. The facility failed to notify the resident of the reason the

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F 156	Continued From page 3 coverage would end. - Review of the Notice of Medicare Provider Non-Coverage for resident #26 revealed a discharge from skilled services dated 2-12-12. The notice lacked the reason for discharge from skilled services. During an interview on 7-26-12 at 2:45 P.M. administrative staff B reported he/she was responsible for typing the forms up, and then he/she handed them to the nurse. Administrative staff B further reported that he/she was not made aware of why a resident was being discharged. During interview on 7-26-12 at 3:16 P.M. administrative nursing staff D reported the reason for discharge was on the resident's record and the nurse gave the resident a copy of the form with their discharge packet. The facility failed to give adequate documentation of the reason for discharge from skilled nursing services.	F 156		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder	F 315		

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F 315	Continued From page 4 function as possible. This REQUIREMENT is not met as evidenced by: The facility identified a census of 55 residents. The sample included 15 residents. Based on observation, interview, and record review the facility failed to provide timely toileting and adequate perineal care for 1 of 2 residents sampled for incontinence. (#32) Findings included: - Resident #32's significant change Minimum Data Set 3.0 Assessment (MDS) dated 6-28-12, documented the resident with impaired short and long term memory and severely impaired decision making skills. The resident required extensive assistance with bed mobility, transfers, ambulation, dressing, eating, toileting, and personal hygiene. The resident was incontinent of bowel and bladder. The incontinence Care Area Assessment (CAA) dated 6-29-12 documented the resident was incontinent of urine and required extensive assistance of one staff for toileting. The CAA documented the resident was unable to make his/her toileting needs known, so staff anticipated his/her toileting needs and toileted the resident before and after meals, at bedtime and as needed. The 2-20-12 bladder assessment documented the resident without a pattern of voiding and voiding frequency was 3-4 times in an 8 hour period.	F 315		

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F 315	Continued From page 5 The 6-29-12 care plan identified the resident with functional incontinence, he/she required extensive assistance with toileting and directed staff to toilet the resident before and after meals, at bedtime and as needed. Observation on 7-25-12 at 8:38 A.M. revealed the resident sat at the dining table and staff assisted him/her with eating breakfast. Observation on 7-25-12 at 8:53 A.M. revealed staff removed the resident from the dining room and transferred the resident from his/her wheelchair into a chair in the living area. Staff did not toilet the resident at this time. Observation on 7-25-12 from 8:53 A.M. until 9:30 A.M. the resident remained in the chair in the living area. At 9:30 A.M. staff transferred the resident from the chair into his/her wheelchair and took the resident to the beauty shop. Staff did not toilet the resident at this time. Observation on 7-25-12 at 10:29 A.M. staff brought the resident into the living area and transferred the resident from his/her wheelchair into a chair in the living area. Staff did not toilet the resident at this time. Observation on 7-25-12 at 10:42 A.M. the resident sat in the living area. Staff did not toilet the resident at this time. Frequent observation on 7-25-12 at 10:58 A.M. until 11:59 A.M. staff transferred the resident from the chair into his/her wheelchair and took the resident to the dining room and placed him/her at	F 315		

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the table. Staff did not toilet the resident during this time.

Frequent observation on 7-25-12 at 12:15 P.M. until 1:23 P.M. the resident remained in his/her wheelchair in the dining room. Staff did not toilet the resident during this time.

Observation on 7-25-12 at 1:23 P.M. direct care staff O removed the resident from the dining room and took the resident to his/her room. Licensed nurse H assisted direct care staff O and placed the resident in his/her bed and left the room. At that time, direct care staff O stated they toilet the resident before and after meals and it was his/her understanding staff toileted the resident before lunch. Direct care staff O then went back into the resident's room and stated he/she would toilet the resident. Direct care staff Q entered the room to assist. Direct care staff Q removed the resident's pull up brief and acknowledged the brief was wet. Direct care staff Q wiped the resident's inner buttock area with incontinence wipes and applied barrier cream on the resident's buttocks area. Direct care staff O placed a clean pull up brief on the resident and they repositioned the resident for comfort.

During staff interview on 7-25-12 at 3:00 P.M. direct care staff P stated that each resident's care plan was on the care tracker computer system and it directed staff on the needs of each resident. Direct care staff P stated staff toileted the resident before and after meals, at bedtime and as needed and the resident was not able to state his/her needs.

During staff interview on 7-26-12 at 8:04 A.M.

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licensed nurse I stated that he/she stated direct care staff documented cares in the care tracker computer system which also provided information staff needed to care for the residents. He/she also stated staff toileted the resident before and after meals, at bedtime, and as needed. Licensed nurse I acknowledged staff failed to toilet the resident before or after meals and stated staff should have taken the resident to the bathroom and sat him/her on the toilet each time.

During staff interview on 7-26-12 at 1:29 P.M. direct care staff Q stated that when he/she provided perineal care for residents, he/she cleansed the front genital area entirely and wiped from front to back then cleaned the buttock area.

During staff interview on 7-26-12 at 3:50 P.M. licensed nurse J stated that staff toileted the resident every 2 hours as the resident was unable to state his/her needs. When providing perineal care staff should wash the entire area exposed to urine which included the front area also.

During staff interview on 7-26-12 at 4:00 P.M. direct care staff R stated that staff should toilet the resident at least every 2 hours and while providing perineal care, staff cleansed the entire perineal area from front to back and cleansed all the skin area exposed to urine.

The 3/11 facility provided Urinary Incontinence policy and procedure documented that residents who were incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and restored as much normal bladder function as possible. If the underlying condition was not reversible, it was

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F 315	Continued From page 8 important to treat or manage the incontinence to try to reduce complications. The facility failed to provide adequate perineal care after an incontinence episode and failed to provide timely toileting for this cognitively impaired, dependent resident.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 55 residents. The sample included 15 residents. Based on observation, interview, and record review the facility failed to provide adequate fall prevention interventions for 1 of 3 residents reviewed for accidents when staff failed to maintain the call light within the resident's reach while sitting in his/her recliner and failed to use a gait belt while staff ambulated the resident. (#60) Findings included: - The admission Minimum Data Set 3.0 Assessment (MDS) dated 6-25-12 documented resident #60's Brief Interview for Mental Status Score (BIMS) of 15, which indicated the resident was alert and oriented. The MDS documented	F 323		

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the resident did not have any falls.

The fall Care Area Assessment summary (CAA) dated 6-26-12 documented the resident was at risk for falls related to impaired balance, ataxia (lack of muscle coordination during voluntary movements), Parkinson's disease (a progressive disorder of the nervous system that affects movement), impaired vision and hearing, restless leg syndrome, and received ativan (an anti-anxiety medication) as needed (PRN). The CAA documented the resident with a history of seizures, wandered into others rooms, ambulated with a roller walker with assistance of 1 staff. The resident admitted to the facility from assisted living after increasing debilitation.

The 6-27-12 care plan documented the resident with glaucoma (an eye disorder that affected vision), incontinence, and at risk for falls related to Parkinson's disease, restless leg syndrome, psychotropic medication use, and seizures. The care plan directed staff to assist the resident with ambulation while he/she used the walker, keep the call light within the resident's use and encourage the resident to use it.

The undated Resident Profile Report the certified nursing assistants (CNAs) referred to for care of the residents lacked documentation that identified the resident was at risk for falls and directed staff to assist the resident with transfers and walking.

The 7-7-12 nurses' notes at 11:15 A.M. documented staff found the resident on the floor near his/her walker and recliner and the resident denied falling. The resident told staff he/she sat on the floor to put his/her pants on.

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The nurses' notes on 7-10-12 at 3:44 A.M. documented staff found the resident at approximately 2:50 A.M. and his/her head was bleeding. Staff asked the resident what happened and he/she stated he/she fell on the floor while he/she slept.

Observation on 7-24-12 at 11:21 A.M. revealed the resident sat in his/her recliner in his/her room and the call light was on the resident's bed out of reach for the resident. The resident complained of pain and wanted pain medication.

Observation on 7-25-12 at 9:41 A.M. revealed the resident sat in his/her recliner and the call light was on the resident's bed out of reach of the resident.

Observation on 7-25-12 at 11:40 A.M. direct care staff Q assisted the resident out of the recliner to the walker. The resident was hunched over at the waist with his/her head down facing the floor while he/she ambulated. Direct care staff Q stood in front on the walker, hung onto the bar across the front of the walker and lead the resident to the dining area. The resident did not have a gait belt on during ambulation.

Observation on 7-25-12 at 1:22 P.M. revealed the resident sat in his/her recliner in his/her room and the call light was on the resident's bed out of reach of the resident.

Observation on 7-26-12 at 8:50 A.M. staff assisted the resident out of the dining chair to his/her walker and the resident was hunched over with his/her head facing the floor and staff

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ambulated beside the resident giving the resident directions which way to go. The resident did not have a gait belt on.

During staff interview on 7-26-12 at 1:29 P.M. direct care staff Q stated the resident was unable to see very well and when he/she ambulated in front of the resident and held onto his/her walker, the resident was able to follow him/her. Direct care staff Q stated when the resident sat in his/her recliner, he/she placed the call light within the resident's reach.

During staff interview on 7-26-12 at 4:00 P.M. direct care staff R stated when staff ambulated the resident they used a gait belt and also kept his/her call light within reach while in his/her room at all times.

During staff interview on 7-26-12 at 1:58 P.M. licensed nurse I stated he/she did not consider the resident a fall risk as he/she liked to lay on the floor and was able to tell staff if he/she had a fall. Licensed nurse I did not expect staff to place a gait belt on the resident as he/she did not consider the resident a fall risk.

During staff interview on 7-26-12 at 3:50 P.M. licensed nurse J stated the resident was a fall risk because of the way the resident bent over when he/she ambulated and staff should use a gait belt on him/her with ambulation and the call light should be within his/her reach.

The 2/08 facility provided Falls policy and procedure documented the facility identified residents at risk for falls and implemented interventions to reduce the risk of falls.

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F 323	Continued From page 12 The facility failed to use a gait belt during ambulation, and failed to keep the resident's call light within his/her reach for this resident identified as a fall risk.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: The facility reported a census of 55 residents. The facility had 4 unit dinning rooms. Based on observation, record review, and interview the facility failed serve food in a sanitary manner for 2 of 4 units on one of one days of the survey. Findings included: - Two East dining room observation on 7/25/12 at 8:33 A.M. revealed direct care staff Y wore a hair net and gloves while serving the morning meal; and direct care staff Y did not wear a facial net to cover her/his beard/mustache. Staff interview on 7/25/12 at 8:39 A.M. with direct care staff Y stated staff wore facial nets to cover	F 371		

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facial hair while serving food; and the dietary supervisor monitored staff during meals.

Staff interview on 7/25/12 at 8:42 A.M. with licensed nursing staff BB stated the certified nursing aides (CNAs) would wear a facial net to cover facial hair (beard/mustache) when serving meals.

Staff interview on 7/25/12 at 12:45 P.M. with dietary staff DD stated the charge nurse was to oversee the CNAs during food service to ensure staff served food properly and in a sanitary manner; and the CNAs received training in food services.

The undated policy and procedure for Hair Restraints revealed hair restraints, hats, and/or beard guards shall be used to prevent hair from contacting exposed food. Facial hair is discouraged. Any facial hair longer than the eyebrow required coverage with a beard guard in the production and dishwashing areas.

The facility failed to serve food in a sanitary manner.

- One East dinning room observation on 7/23/12 at 12:00 P.M. revealed an unidentified staff assisted a resident with eating, touched her/his side of her/his face, and continued to feed the resident without washing or using hand sanitizer on her/his hands.

- One East dinning room observation on 7/23/12 at 12:22 P.M. revealed a certified nursing aide (CNA) fed one resident, left the resident and

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assisted another resident, repositioned her/his clothing protector then began feeding the original resident again. The CNA cleared the tables for several residents, went to the refrigerator and got a drink of water for her/himself, sat down beside a resident and assisted and encouraged the resident to eat without washing or using hand sanitizer on her/his hands.

- Two East dining room observation on 7/23/12 at 12:30 PM revealed direct care staff JJ removed a cake from a pan with gloved hands and put the cake on a plate and touched the cake with gloved hands after touching the side of the cake pan and counter tops. Direct care staff X entered the serving area without a hairnet, put on gloves, and then put on a hairnet with the gloves still on and began serving cake to residents. She/he touched the cake with the gloved hands after putting on the hairnet and without washing or using hand sanitizer on her/his hands. She/he removed the gloves and served cake to the residents.

Staff interview on 7/25/12 at 12:45 P.M. with dietary staff DD stated the charge nurse was to oversee the CNAs during food service to ensure staff served food properly and in a sanitary manner; and the CNAs received training in food services.

The facility failed to serve food in a sanitary manner.

- Two North dining room observation on 7/23/12 at 12:15 P.M. revealed unidentified dietary staff, while plating up food to be served to the residents, wore a hat that did not contain all of

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F 371	Continued From page 15 his/her hair. Interview with dietary staff DD on 7/25/12 at 12:25 P.M. stated the direct care staff received training in food services. Interview with administrative staff A on 7/30/12 at 1:30 P.M. stated he/she expected the dietary staff working with food would have their hair covered. The undated policy and procedure for Hair Restraints revealed hair hats shall be used to prevent hair from contacting exposed food. The facility failed to serve food in a sanitary manner.	F 371		
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: The facility reported a census of 55 residents.	F 411		

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The sample included 15 residents. Based on observation, record review, and interview, the facility failed to provide dental services for one (#13) of two residents sampled for dental services.

Findings included:

- The significant change Minimum Data Set (MDS) dated 3-30-12 for resident #13 revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. The resident required extensive assist of two plus persons for personal hygiene.

The care plan dated 6-22-12 for self care deficit revealed the resident required set up assist with eating; extensive assistance of one to two activities of daily living (ADL) such as hygiene; prompting to complete ADLs; education and re-education on hygiene cares; assistance with oral cares every A.M., P.M., and as needed. The care plan directed staff to provide a dental consult if the resident requested and per physician order.

The abnormal involuntary movement scale screening (AIMS) dated 2-27-12 at 7:11 A.M. revealed the resident wore dentures without problems. At 5:41 P.M. the AIMS screening revealed the resident did not wear dentures or have dental problems.

The AIMS dated 3-28-12 at 2:38 P.M. and 9:15 P.M. revealed the resident wore dentures without problems.

The oral exam detail dated 3-28-12 and 6-20-12 revealed the resident had normal teeth.

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The AIMS dated 6-20-12 at 7:11 A.M. revealed the resident wore dentures without problems. At 5:41 P.M. it revealed the resident did not wear dentures and had no dental problems.

The Physician Order Set (POS) for July 2012 revealed an order for a dental consult as needed.

The certified nurses aide (CNA) care plan/resident profile dated 7-30-12 revealed the resident required assist of one person with oral care.

Observation on 7-25-12 at 12:15 P.M. resident sat in dining room and ate a bowl of soup without difficulty. At 12:30 P.M. the resident fed him/herself a chicken breast sandwich. He/she consumed 25 percent of the chicken breast and 100 percent of the baked beans. He/she did not grimace or verbalize any difficulty chewing.

Observation on 7-26-12 at 3:16 P.M. the resident removed his/her lower partial. The resident had three natural teeth on the front lower jaw which were brownish-black in color and worn down to the gum line.

Observation on 7-30-12 at 11:50 A.M. staff took the resident to the dining room table, and staff served him/her juice. Direct care staff T asked the resident if he/she had put his/her dentures in. The resident replied he/she had not. Direct care staff T asked the resident if he/she would like him/her to get the dentures so he/she could eat breakfast. The resident agreed. The resident's teeth were not brushed.

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Staff interview on 7-25-12 at 3:30 P.M. with licensed nursing staff K reported the resident performed all of his/her oral cares. Staff assisted as needed, however he/she could be combative and uncooperative in the mornings. In the evenings the resident completed his/her own oral care. Staff completed oral assessments quarterly. The resident refused to have a hygienist clean his/her teeth.

Staff interview on 7-26-12 at 11:45 A.M. with social services staff GG reported he/she met with the resident's family a couple weeks ago because he/she had concern that the resident did not have his/her teeth cleaned. Social services staff GG informed family that the resident was not on the hygienist list which resulted in cleanings not being offered. The resident's family requested the resident be on the hygienist list.

Resident interview on 7-26-12 at 1:00 P.M. revealed he/she did not see the dentist often because he/she did not make appointments to go. He/she had a top and bottom partial that fit without problems. He/she did not remember having his/her teeth cleaned by a hygienist and he/she brushed his/her teeth by him/herself.

During interview on 7-26-12 at 3:16 P.M. he/she denied that staff offered dental care to him/her at the facility and nobody cleaned his/her teeth.

Staff interview on 7-26-12 at 3:25 P.M. with licensed nursing staff L reported the resident required set up assist with oral care supplies by staff in the morning and evening. Nursing staff assessed the resident's oral status quarterly with the AIMS form. The resident was on the

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hygienist's list for next month, and it had been his/her request not to have his/her teeth cleaned by the hygienist.

Staff interview on 7-26-12 at 3:40 P.M. with direct care staff S reported the resident was compliant with his/her oral cares in the evening. He/she asked for the cup to place the upper and lower dentures in when he/she was ready to take them out. Staff placed the dentures in the cleaning cup with denture cleaner.

Staff interview on 7-30-12 at 11:30 A.M. with direct care staff T reported the resident's dentures were in a cleanser overnight. The dentures were rinsed off in the morning when the resident was ready to put them in. The resident was compliant with putting his/her dentures in. Staff set up the supplies for brushing, but the resident sometimes refused to brush his/her natural teeth.

Staff interview on 7-30-12 at 12:00 P.M. with administrative nursing staff E reported the process of completing the dental section on the MDS consisted of asking the resident if he/she had any pain in the mouth or difficulty eating. If the resident denied both, a further assessment was not completed. The nursing staff completed a quarterly dental assessment which contained visual assessment information, and residents had their teeth cleaned on a regular basis. Staff obtained information to complete the MDS from all other sources of documentation.

Staff interview on 7-30-12 at 1:45 P.M. with administrative nursing staff D reported nursing staff completed oral assessments annually which

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F 411	Continued From page 20 consisted of the resident opening their mouth so staff could visualize the oral cavity, then questions about their mouth, teeth, and assessed for any pain or problems. The revised policy and procedure dated 4/11 for Dental Services, revealed staff assessed residents for oral/dental needs initially and periodically using the resident assessment instrument (RAI) specified by the state, but no less than annually; staff assisted in making appointments and arranged transportation to and from the dentist's office. The facility failed to accurately assess this resident for dental services needed and failed to provide routine dental services for this resident.	F 411		